2015 Medical Individual Platinum and Gold Plans

Plan ID/	42260NH0110006		96751NH0150023	96751NH0330006	59025NH0290001	59025NH0270010	19304NH0120001		61163NH0030001	42250NH011000E	
Form Schedue #	42260INHU110006		30/31N10130023				19304NH0120001		0110311110030001	42260NH0110005	
Issuer	Time (Assurant)		Anthem	Anthem	Harvard Pilgrim	Harvard Pilgrim	Maine CHO		Minuteman Health	Time (Assurant)	
Plan Name	Assurant Health Platinum Plan 002			Anthem Blue Cross and Blue Shield Gold DirectAccess, a Multi- State Plan	Harvard Pilgrim ElevateHealth Gold HSA HMO	Harvard Pilgrim NH HMO Gold	Community Advantage		MyDoc HMO Gold Basic 1000	Assurant Health Gold Plan 002	
Metal Level	Platinum		Gold	Gold	Gold	Gold		Gold Gold		Gold	
Product Type	PPO		НМО	HMO	НМО	HMO	PPO		НМО	PPO	
Network Coverage	<u>NHN001</u>		<u>NHN002</u>	<u>NHN201</u>	<u>NHN002</u>	<u>NHN003</u>	<u>NHN001</u>		<u>NHN001</u>	<u>NHN001</u>	
	In-Network	Out-Of-Network					In-Network	Out-Of-Network		In-Network	Out-Of-Network
Deductible-Individual/Family	\$0 / \$ 0	\$5000 / \$10000	\$1000 / \$2000	\$1000 / \$2000	\$1500 / \$3000	\$1000 / \$2000	\$650 / \$1300	\$2500 / \$5000	\$1000 / \$2000	\$0 / \$0	\$5000 / \$10000
Coinsurance	25%	50%	10%	10%	10%	10%	20%	40%	20%	25%	50%
Max Out of Pocket-Individual/Family	\$2000 / \$4000	\$10000 / \$20000	\$3500 / \$7000	\$3500 / \$7000	\$2700 / \$5400	\$5750 / \$11500	\$4000 / \$8000	\$8000 / \$16000	\$3500 / \$7000	\$6350 / \$12700	\$10000 / \$20000
Preventive Care	No Charge	50% Coinsurance after deductible	No Charge	No Charge	No Charge	No Charge	No Charge	Not Covered	No Charge	No Charge	50% Coinsurance after deductible
PCP Visits (not wellness)	\$ 25	50% Coinsurance after deductible	\$ 30	\$ 30	10% Coinsurance after deductible	\$ 20	\$ 20		\$ 30	\$ 25	50% Coinsurance after deductible
Specialist Visits	\$ 25	50% Coinsurance after deductible	10% Coinsurance after deductible	10% Coinsurance after deductible	10% Coinsurance after deductible	\$ 60	\$ 75	40% Coinsurance after deductible	20% Coinsurance after deductible	\$ 25	50% Coinsurance after deductible
Urgent Care	25% Coinsurance after deductible	50% Coinsurance after deductible	\$50 Copay and 10% Coinsurance after deductible	\$50 Copay and 10% Coinsurance after deductible	\$75 Copay after deductible	\$ 75	\$ 75		20% Coinsurance after deductible	25% Coinsurance after deductible	50% Coinsurance after deductible
Outpatient Facility/Surgical Center	25% Coinsurance after deductible	50% Coinsurance after deductible	10% Coinsurance after deductible	10% Coinsurance after deductible	10% Coinsurance after deductible	10% Coinsurance after deductible	20% Coinsurance after deductible	40% Coinsurance after deductible	20% Coinsurance after deductible	25% Coinsurance after deductible	50% Coinsurance after deductible
Emergency Room	\$100 Copay before deductible, and 25% Coinsurance after deductible	\$100 Copay before deductible, and 25% Coinsurance after deductible	\$200 Copay and 10% Coinsurance after deductible	\$200 Copay and 10% Coinsurance after deductible	\$200 Copay after deductible	\$200 Copay after deductible	\$ 375	\$ 375	20% Coinsurance after deductible	\$100 Copay before deductible, and 25% Coinsurance after deductible	\$100 Copay before deductible, and 25% Coinsurance after deductible
Inpatient Hospital Services			\$500 Copay per Stay; 10% Coinsurance after deductible	\$500 Copay per Stay; 10% Coinsurance after deductible					20% Coinsurance after deductible	25% Coinsurance after deductible	
Generic Drugs	\$ 10	\$ 10	\$ 15	\$ 15	\$5 Copay after deductible	\$ 15	\$ 10	40% Coinsurance after deductible	\$ 10	\$ 15	\$ 15
Preferred Brand Drugs	\$ 30	•	\$ 40	\$ 40	\$20 copay after deductible	\$45	\$ 25	40% Coinsurance after deductible	30%	\$ 35	\$ 35
Durable Medical Equipment	deductible	deductible	10% Coinsurance after deductible	10% Coinsurance after deductible	10% Coinsurance after deductible	10% Coinsurance after deductible	20% Coinsurance after deductible	deductible	20% Coinsurance after deductible	deductible	deductible
Chiropractic Care	25% Coinsurance after deductible	50% Coinsurance after deductible	10% Coinsurance after deductible	10% Coinsurance after deductible	10% Coinsurance after deductible	\$ 20		40% Coinsurance after deductible	\$ 30	25% Coinsurance after deductible	50% Coinsurance after deductible
Adult Dental Embedded?	No	No	No	No	No	No	No	No	No	No	No
Routine Dental Adult	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Dental Embedded?	Yes	Yes	No	Yes	No	No	No	No	No	Yes	Yes
Dental Check-Up for Children	No Charge	No Charge	Not Covered	10% Coinsurance after deductible	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	No Charge	No Charge